MEDICAL STATEMENT FOR CONSIDERATION OF CARE GIVER OR CARE RECEIVER ASSISTANCE

Date: _____

Patient's Name: _____

Dear Doctor:

The above named patient has requested a temporary use permit to allow a second residence on property because of extreme personal hardship. Generally, this is requested when, due to illness or other infirmity, on-site assistance is required for the patient's health and well being.

Please affirm that due to medical concerns, your patient requires continuous necessary medical care and oversight that requires an on-site caregiver.

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.
PHYSICIAN'S NAME & ADDRESS
(Please type or print)

_____

_____

_____

_____
Examining Doctor's Signature

_____
Examining Doctor's State Medical License Number

<u>This must be signed by a Medical Doctor (MD) or Doctor of Osteopathy (DO).</u>

<u>This document will ONLY be accepted on the Examining Physician's letterhead.</u>